Challenges to Critical Care in India

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Lack of Recognition: Beginning of ISCCM

- For many years CCM not recognized as a separate specialty
- In 1993 a group of 13 doctors met in Mumbai & conceived ISCCM
- First National ISCCM conference held in Mumbai in 1994
- Continuous efforts to get MCI to recognize CCM as a super-specialty
- ISCCM starts its own course IDCCM, IFCCM
Progress

• Current Membership is 7800 doctors & nurses
• National Board of Examination (NBE) starts a 2 year Fellowship in Critical Care Medicine (FNB)
• Continuous efforts by ISCCM bear fruit & a 3 year DM (CCM) course approved by MCI in 2011
• First DM (CCM) student passed in 2015
• Only 4 centers offering DM course
• Dearth of manpower still persists
Lack of Standardization

• There is NO national health service
• The critical care services offered vary from center to center.
• Spectrum
  – No ICU care available in rural areas
  – Level II care in Govt hospitals
  – State of the art services & technology available in Corporate sectors
• No accreditation of ICUs at national level
Prehospital Care

• There are no prehospital services
  – No infrastructure in many regions of country
  – Trained manpower unavailable
  – No on-site treatment
• Patients reach hospitals & ICUs quite late
• This actually affects the outcomes adversely in most cases
• Some states have started waking up & making prehospital care available
EBM

- Many of our pts suffer from tropical diseases, poisoning patterns are different from the western countries
- No western literature on these diseases
- There is a paucity of data or RCTs from our country mainly because of lack of manpower as well as absence of culture to research
- ISCCM has published guidelines for this and we further plan to collect data and/or conduct trials to fill these lacunae
Antibiotics

• Western literature suggests a shift towards a prevalence with Gm+ve organisms
• In India our predominant infectious organisms in intensive care & community are still Gm - ve organisms
• Majority are resistant organisms
• ISCCM conducted a study named Multi-center Observational Study to Evaluate Epidemiology and Resistance Patterns of Common ICU- Infections (MOSER) to get Indian data
• Basic EOL Healthcare Environment
• Availability of EOL Care
• Cost of EOL Care
• Quality of EOL Care.
End of Life Care

• Barriers
  – Market forces & pts’ demands for the “best” treatment: physician’s renumeration
  – “Paternalistic” attitude: reluctant to discuss EOL to shield families from emotional trauma
  – Little orientation in medical schools to palliative care & management of death
  – Rising incidence of litigation – safer to continue therapy
  – Lack of social awareness of forgoing life support as an acceptable option
  – The issue of forgoing life support is misinterpreted as suicide or abetting suicide

• ISCCM published the first position statement on EOL in 2005, recently updated in 2015
Critical Care for Poor

- India spends about 1% GDP on public health, (China 3% & USA 8.3%)
- Poor penetration of health insurance in poorer household
  - Health insurance 5-10%
  - Employers account for around 9%
  - Personal expenditure 82%
- Most pts thus can not afford routine hospitalization let alone ICU care
- ISCCM is trying to spread awareness about insurance